



Pelvic Floor Questionnaire

Please bring a hard copy of this form to your appointment. To maintain your privacy, please do not email or fax this form to us.

Name: _____ Date _____ Age _____
Occupation: _____ Hours per week _____

Please describe the problem you are being seen for? _____
How long has this been a problem for you? _____

Are you anticipating a surgery for this problem? Y/N

Medical History:

Please check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Emphysema/Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer(type)_____ | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Respiratory allergies | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> HIV/AIDS |

Women

- Prolapse/Cystocele/Rectocele
- Painful menstruation
- Painful vaginal penetration
- Pelvic Pain
- Menopause
- Hysterectomy
- Endometriosis
- Vaginal births # _____
- Episiotomy # _____
- Cesareans # _____
- Childbirth Complications _____
- Pregnant/attempting Pregnancy? Y/N
- IUD Currently? Y/N

Surgeries: (abdominal, back, bladder, prostate, female organs)

Date of last pelvic/prostate exam: _____ Date of last urinalysis: _____

Special tests performed: Type _____ Date _____

Please list any medications you are taking including over the counter medications and herbs.

What is your current level of exercise? _____

Have you been taught how to do pelvic floor or Kegel exercises? Y/N

By whom? _____ Do you do them now? Y/N

If you are being seen for urinary/fecal incontinence or this is part of your problem, please complete the next page.

If you are being seen for pelvic pain you will be given an additional questionnaire to complete at your first appointment.

Urinary/Bowel Symptoms

Please check your responses in the following sections. **Skip any that do not apply** .

1. Occurrence of incontinence or leakage:

Urine		Bowel
_____	Never	_____
_____	Less than 1 month	_____
_____	More than 1 month	_____
_____	Less than 1 week	_____
_____	More than 1 week	_____
_____	Almost every day	_____
_____	More than 1/day # _____	_____

5. Strong urine or bowel urgency? Y/N

How long can you delay the need to urinate?

_____ 30 to 60 minutes
_____ 15 to 30 minutes
_____ Less than 15 minutes
_____ Not at all

2. Protection worn:

_____ Poise/Serenity
_____ None
_____ Panti-shields
_____ Mini pad
_____ Maxi pad

6. Frequency of urination: (daytime)

_____ 1-4 times per day
_____ 5-8 times per day
_____ 9-12 times
_____ 13+ times

3. Severity:

Urine		Bowel
_____	No leakage	_____
_____	Few drops	_____
_____	Wet underwear	_____
_____	Wet outerwear	_____

7. Frequency of urination: (nighttime)

_____ 0 times per night
_____ 1 time
_____ 2 times
_____ 3 times
_____ 4+

4. Activity that causes loss:

_____ Vigorous activity (running, exercise)
_____ Light activity (house work, walking)
_____ No activity
_____ Changing position sit to stand
_____ Sexual activity
_____ Strong urge
_____ Cough/sneeze/laugh

8. Fluid intake: (water and beverages)

_____ 9+, 8oz glasses per day
_____ 6-8 glasses
_____ 3-5 glasses
_____ 1-2 glasses
_____ How many of these are caffeinated?

Any other comments or concerns?
